

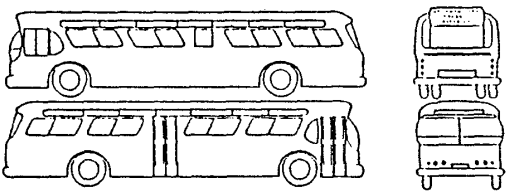
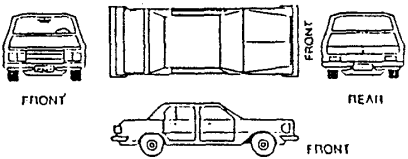
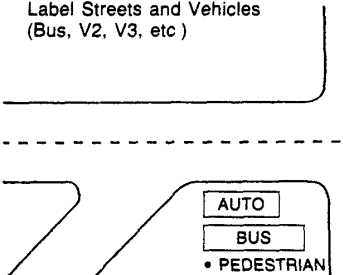
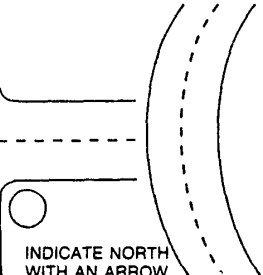
APPENDIX G

Examples of Accident Report Forms

Some transit systems have different reports for passenger accidents and vehicle collisions, and some use only one form for both incidents. Most transit systems also have a supervisor's

report of the accident. Examples from three transit systems of accident/incident and supervisor forms are given in the following pages.

PHOENIX TRANSIT SUPERVISOR'S FIELD NOTES AND ACCIDENT REPORT					
REPORT NUMBER / /		1 <input type="checkbox"/> COLLISION 2 <input type="checkbox"/> PTS PROPERTY DAMAGE			
DATE OF ACCIDENT / /		DAY OF WEEK M T W T F S S		TIME : AM / PM	
PTS VEHICLE #		NUMBER OF COURTESY CARDS		DIRECTION OF TRAVEL N S E W	
ROUTE		PLACE ACCIDENT OCCURRED: CITY			
ON WHAT STREET:		INTERSECTING STREET:			
WEATHER CONDITIONS	STREET CONDITION	LIGHT CONDITIONS	TYPE OF ACCIDENT	DRIVER'S CONDITION	WERE PICTURES TAKEN
<input type="checkbox"/> CLEAR <input type="checkbox"/> CLOUDY <input type="checkbox"/> RAIN <input type="checkbox"/> FOG	<input type="checkbox"/> WET <input type="checkbox"/> DRY <input type="checkbox"/> ICY	<input type="checkbox"/> DAYLIGHT <input type="checkbox"/> DUSK <input type="checkbox"/> DAWN <input type="checkbox"/> DARK	<input type="checkbox"/> ANGLE <input type="checkbox"/> HEAD-ON <input type="checkbox"/> REAR-END	<input type="checkbox"/> COMPOSED <input type="checkbox"/> UPSET <input type="checkbox"/> INJURED	<input type="checkbox"/> YES <input type="checkbox"/> NO
TRANSIT VEHICLE			OTHER VEHICLE		
DRIVER VEHICLE	NAME (LAST, FIRST, MIDDLE)		NAME (LAST, FIRST, MIDDLE)		
	ADDRESS		ADDRESS		
	CITY	STATE ZIP	CITY STATE ZIP		
	DRIVER'S LIC # STATE		DRIVER'S LIC # STATE		
	OWNER (LAST, FIRST, MIDDLE)		OWNER (LAST, FIRST, MIDDLE)		
	ADDRESS		ADDRESS		
	CITY	STATE ZIP	CITY STATE ZIP		
LIC # YEAR MAKE COLOR		LIC # YEAR MAKE COLOR			
WERE THERE ANY INJURIES <input type="checkbox"/> YES <input type="checkbox"/> NO					
NAME	ADDRESS, CITY, STATE, ZIP	PHONE	AGE	SEX	NATURE
(on pts bus)					
(other vehicle)					
POLICE REPORT #		POLICE OFFICER			

WERE INJURED TRANSPORTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		BY WHOM?	WHERE TAKEN?
IF A COLLISION WITH AN OBJECT			
DESCRIBE OBJECT			
EXTENT OF DAMAGE TO OBJECT			
LOCATION OF OBJECT			
NAME OF OWNER	ADDRESS	PHONE	
BASED ON YOUR OBSERVATIONS, WHAT DIRECTLY CAUSED THE ACCIDENT: <input type="checkbox"/> VISIBILITY <input type="checkbox"/> SPEED OF BUS <input type="checkbox"/> WEATHER <input type="checkbox"/> OTHER VEHICLE <input type="checkbox"/> OPERATOR ERROR <input type="checkbox"/> ROAD HAZARD <input type="checkbox"/> VANDALISM <input type="checkbox"/> OTHER EXPLAIN. _____			
MARK DAMAGED AREAS OF VEHICLES			
			
DAMAGE DESCRIPTION _____		DAMAGE DESCRIPTION _____	
DRAW A DIAGRAM OF ACCIDENT WITH ALL VEHICLES INVOLVED:			
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p style="font-size: small;">Label Streets and Vehicles (Bus, V2, V3, etc)</p>  <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;"> AUTO BUS • PEDESTRIAN </div> </div> <div style="width: 45%;">  <p style="font-size: small;">INDICATE NORTH WITH AN ARROW</p> </div> </div> <p style="text-align: center; font-size: small;">PLEASE INDICATE WITH AN "X" WHERE YOU FIRST SAW HAZARD</p>			
SUPERVISOR SIGNATURE		DATE	

PHOENIX TRANSIT PASSENGER ACCIDENT/INCIDENT REPORT

EMPLOYEE _____		BUS # _____		
DATE / / DAY		TIME : AM : PM		
ROUTE _____		LOCATION _____		
<input type="checkbox"/> INJURY	<input type="checkbox"/> FARE EVASION	<input type="checkbox"/> ALTERCATION	<input type="checkbox"/> VANDALISM	
<input type="checkbox"/> ONBOARD <input type="checkbox"/> ALIGHTING <input type="checkbox"/> BOARDING <input type="checkbox"/> SITTING	<input type="checkbox"/> COIN <input type="checkbox"/> DOLLAR <input type="checkbox"/> TRANSFER	<input type="checkbox"/> OP/PASS <input type="checkbox"/> PASS/PASS <input type="checkbox"/> STUDENTS	<input type="checkbox"/> ONBOARD <input type="checkbox"/> OUTSIDE	
WAS PASSENGER REMOVED BY?		<input type="checkbox"/> AMBULANCE <input type="checkbox"/> POLICE <input type="checkbox"/> SUPERVISOR		
PASSENGER'S APPEARANCE <input type="checkbox"/> APPARENTLY NORMAL <input type="checkbox"/> ILL <input type="checkbox"/> INTOXICATED <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> UNCONSCIOUS		POINT OF OCCURRENCE <input type="checkbox"/> FRONT STEPS <input type="checkbox"/> BEFORE ENTERING BUS <input type="checkbox"/> REAR STEPS <input type="checkbox"/> AFTER LEAVING BUS <input type="checkbox"/> FRONT OF BUS <input type="checkbox"/> APPROACHING BUS STOP <input type="checkbox"/> MIDDLE OF BUS <input type="checkbox"/> STANDING AT BUS STOP <input type="checkbox"/> REAR OF BUS		
DID ANOTHER VEHICLE CAUSE THE ACCIDENT/INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
LICENSE # _____ STATE _____ MAKE _____ YEAR _____ COLOR _____				
ACTION OF VEHICLE: <input type="checkbox"/> STOPPING <input type="checkbox"/> MOVING TO CURB <input type="checkbox"/> TURNING LEFT <input type="checkbox"/> STARTING <input type="checkbox"/> MOVING FROM CURB <input type="checkbox"/> TURNING RIGHT <input type="checkbox"/> CROSSING INTERSECTION <input type="checkbox"/> CHANGING LANES				
ACTION OF BUS: <input type="checkbox"/> COMING TO STOP <input type="checkbox"/> STANDING STOP <input type="checkbox"/> STARTING UP <input type="checkbox"/> EMERGENCY STOP <input type="checkbox"/> OTHER — EXPLAIN _____ _____ _____				
NAME OF INJURED	ADDRESS, CITY, ZIP	PHONE	AGE	INJURIES
1. _____				
2. _____				
3. _____				
WITNESSES	ADDRESS, CITY, ZIP	PHONE	AGE	INJURIES
1. _____				
2. _____				
3. _____				





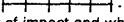
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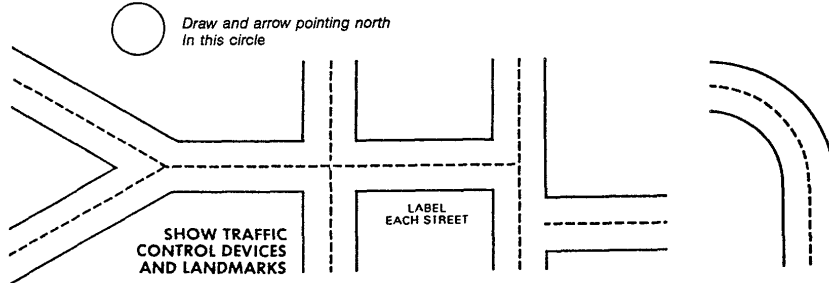
BUS OPERATOR ACCIDENT-INCIDENT REPORT Fill In All Blanks Applicable - Be Specific (Use Black Ink Only)		Division _____		
		File No _____		
OPERATOR _____		ID# _____	BLOCK# _____	BUS# _____
DAY/DATE OF ACCIDENT _____	TIME OF ACCIDENT _____ M	NO PASSENGERS ON BUS _____	NO. COURTESY CARDS DISTRIB _____	APPROX. SPEED AT TIME OF INCIDENT: _____ MPH
LOCATION OF ACCIDENT (Include Town) _____				
TYPE OF OCCURENCE <input type="checkbox"/> COLLISION—INJURIES <input type="checkbox"/> PASSENGER—INJURIES <input type="checkbox"/> INCIDENT—NO INJURIES <input type="checkbox"/> INCIDENT—INJURIES <input type="checkbox"/> COLLISION—NO INJURIES <input type="checkbox"/> PASSENGER—NO INJURIES	WEATHER CONDITIONS <input type="checkbox"/> CLEAR <input type="checkbox"/> RAINING <input type="checkbox"/> FOG <input type="checkbox"/> SNOWING <input type="checkbox"/> SLEET <input type="checkbox"/> _____	ROAD CONDITIONS <input type="checkbox"/> DRY <input type="checkbox"/> WET <input type="checkbox"/> ICY <input type="checkbox"/> SNOWY <input type="checkbox"/> SLUSHY <input type="checkbox"/> _____	MOTION OF BUS <input type="checkbox"/> STOPPED — TRAFFIC <input type="checkbox"/> STOPPED — BUS STOP <input type="checkbox"/> BRAKING <input type="checkbox"/> ACCELERATING <input type="checkbox"/> TURNING <input type="checkbox"/> OTHER	LIGHT CONDITIONS <input type="checkbox"/> DAYLIGHT <input type="checkbox"/> DAWN/DUSK <input type="checkbox"/> DARK — NO LIGHT <input type="checkbox"/> DARK — STREET LIGHTS
BUS HEADLIGHTS <input type="checkbox"/> ON <input type="checkbox"/> OFF				
Complete the Following if COLLISION				
PLATE # OF OTHER VEHICLE _____	MAKE/MODEL/YEAR/COLOR _____	NO PASSENGERS IN OTHER VEHICLE _____	DIRECTION OF BUS (Circle) _____	DIRECTION OF OTHER VEHICLE (Circle) _____
STATE: _____			N S E W	N S E W
NAME OF OTHER DRIVER _____	DRIVER'S LICENSE NO _____	STATE: _____	OWNER OF OTHER VEHICLE _____	
ADDRESS OF OTHER DRIVER _____	STREET: _____	ADDRESS OF OWNER _____	STREET: _____	
CITY: _____	STATE: _____	CITY: _____	STATE: _____	
DAMAGE TO BUS YES _____ NO _____ (If Yes Fill Out Vehicle Damage Sheet)		DESCRIBE DAMAGE TO OTHER VEHICLE OR PROPERTY _____		
INSURANCE CARRIER OR AGENT & CODE # _____		INSURANCE POLICY NO. _____		
Complete the Following if PASSENGER INJURY (Check all that apply)				
NATURE OF ACCIDENT <input type="checkbox"/> FRONT STEPS <input type="checkbox"/> WHILE BOARDING <input type="checkbox"/> AFTER BOARDING <input type="checkbox"/> ALIGHTING <input type="checkbox"/> SEATED <input type="checkbox"/> STANDING	<input type="checkbox"/> REAR STEPS <input type="checkbox"/> FRONT DOOR <input type="checkbox"/> REAR DOOR <input type="checkbox"/> OFF BUS	NATURE OF INJURY <input type="checkbox"/> HEAD <input type="checkbox"/> ARM <input type="checkbox"/> LEG <input type="checkbox"/> HAND <input type="checkbox"/> FOOT <input type="checkbox"/> BODY	<input type="checkbox"/> BLEEDING <input type="checkbox"/> BRUISE <input type="checkbox"/> FRACTURE <input type="checkbox"/> MULTIPLE INJURY <input type="checkbox"/> NOTHING VISIBLE	CONDITION OF STEPS <input type="checkbox"/> DRY <input type="checkbox"/> WET (RAIN) <input type="checkbox"/> WET (SNOW) <input type="checkbox"/> ICY <input type="checkbox"/> OTHER
		KNEELER <input type="checkbox"/> UP <input type="checkbox"/> DOWN LIFT/RAMP <input type="checkbox"/> IN USE <input type="checkbox"/> NOT IN USE	BUS UP TO CURB? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF STOPPED, NOT UP TO CURB, GIVE REASON _____ LIC # OF VEHICLE IN BUS STOP _____
FOR ALL PASSENGER INJURIES, INDICATE LOCATION OF PASSENGER ON THIS DIAGRAM AND SHOW LOCATION OF CURB (IF BOARDING OR ALIGHTING ACCIDENT). IF OFF BUS, INDICATE APPROXIMATE DISTANCE FROM BUS.				
Witnesses: _____		(2) _____	(3) _____	(4) _____
Name _____				
Address _____				
City _____				
Phone No. _____				

PART A (PROVIDE A DIAGRAM FOR ALL COLLISION AND PASSENGER ACCIDENTS)

DRAW A DIAGRAM OF WHAT HAPPENED, USING THE APPROPRIATE GUIDE BELOW

INSTRUCTIONS:

1. Number each vehicle (Show bus as number 1) and show direction of travel with arrow:
Use solid line to show direction prior to collision  , Use broken line to show direction after collision  2
2. Show pedestrian as  and bicyclist as  .
Show railroad tracks as  .
3. Be sure to show the point of impact and where the vehicles came to rest.



PERSONS INVOLVED OR INJURED	Were police at scene of accident? Yes _____ No _____ Officers' Badges _____					Passenger	Pedestrian	Other Veh.	Approx. Age
	Officer's Name _____ Police Dept. _____								
	Names	Address	City	Phone No.	Apparent Injuries				
	1 _____								
	2 _____								
	3 _____								
	4 _____								
5 _____									
6 _____									
Ambulance? Yes _____ No _____ Hospitalized? Yes _____ No _____ Name of Hospital _____									

DESCRIBE THE ACCIDENT OR INCIDENT IN DETAIL (Include condition of platform and steps if passenger accident occurred while boarding or alighting)

OPERATOR'S SIGNATURE _____

(OVER)

DATE OF THIS REPORT _____

*Use Additional Blank Sheets if Necessary.

LOCAL OFFICE USE ONLY			
ACC TYP	VEH CODE	OPR RESP	REPORT CHECKED BY:

REPORT OF ACCIDENT OR UNUSUAL OCCURRENCE

CLASSIFICATION _____

ACCIDENT
REPORT NO. _____

DATE OF ACCIDENT _____

TIME _____ AM PM

INSURANCE

COMPANY _____ CITY _____

CLAIM NO. _____
STATE _____

STREET ON WHICH ACCIDENT OCCURRED:	AT INTERSECTION WITH:
IF NOT AT INTERSECTION: _____ FT. <input type="checkbox"/> N. <input type="checkbox"/> S. <input type="checkbox"/> E. <input type="checkbox"/> W.	NEAREST INTERSECTING STREET:

VEHICLE NO 1 (transit vehicle) DRIVER'S NAME: DRIVER'S ADDRESS: WITH CO. YRS. VEHICLE NO. CHAUFFEUR LIC. NO. ROUTE RUN NO. C.S.O. NO. PARTS VEHICLE DAMAGED: INVESTIGATION BY: <input type="checkbox"/> CITY POLICE <input type="checkbox"/> COMPANY <input type="checkbox"/> STATE POLICE <input type="checkbox"/> SHERIFF <input type="checkbox"/> OTHER OBSERVER'S NAME AND ADDRESS:	VEHICLE NO 2 (other vehicle) DRIVER'S NAME: PHONE NO. DRIVER'S ADDRESS: CITY STATE DRIVER'S LIC. NO. STATE BIRTHDATE INSURANCE COMPANY VEHICLE MAKE YEAR LIC. NO. STATE REGISTERED OWNER: OWNER'S ADDRESS: PARTS OF VEHICLE DAMAGED: NAMES OF OTHER OCCUPANTS:
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(If more space needed-attach supplemental list)

PERSON(S) INJURED: ☐ In bus ☐ Other vehicle ☐ Pedestrian

NAME:
Injured Removed By: <input type="checkbox"/> Ambulance <input type="checkbox"/> Aid Car <input type="checkbox"/> Police <input type="checkbox"/> Fire Dept. <input type="checkbox"/> Supervisor <input type="checkbox"/> Other

TYPE ACCIDENT:	WEATHER:	ROAD CONDITION:	ROAD SURFACE:	TRAFFIC CONTROL:
Check one <input type="checkbox"/> traffic <input type="checkbox"/> passenger <input type="checkbox"/> pedestrian <input type="checkbox"/> observation <input type="checkbox"/> miscellaneous <input type="checkbox"/> vandalism <input type="checkbox"/> other	Check one <input type="checkbox"/> clear <input type="checkbox"/> cloudy <input type="checkbox"/> rainy <input type="checkbox"/> snowing <input type="checkbox"/> foggy <input type="checkbox"/> sleet <input type="checkbox"/> other	Check one <input type="checkbox"/> dry <input type="checkbox"/> wet <input type="checkbox"/> icy <input type="checkbox"/> snowy <input type="checkbox"/> muddy <input type="checkbox"/> other	Check one <input type="checkbox"/> concrete <input type="checkbox"/> blacktop <input type="checkbox"/> gravel <input type="checkbox"/> dirt <input type="checkbox"/> brick or <input type="checkbox"/> cobble <input type="checkbox"/> other	Check one <input type="checkbox"/> stop sign <input type="checkbox"/> yield sign <input type="checkbox"/> traffic signal <input type="checkbox"/> RR semaphore <input type="checkbox"/> flagman <input type="checkbox"/> no control <input type="checkbox"/> other

PASSENGER ACCIDENT (check one or more)

<input type="checkbox"/> fell boarding <input type="checkbox"/> fell in bus <input type="checkbox"/> fell before boarding <input type="checkbox"/> fell alighting <input type="checkbox"/> fell after alighting <input type="checkbox"/> ft. from curb	<input type="checkbox"/> front door <input type="checkbox"/> rear door (push type) <input type="checkbox"/> rear door (manual) <input type="checkbox"/> struck by doors <input type="checkbox"/> starting <input type="checkbox"/> stopping	<input type="checkbox"/> straight <input type="checkbox"/> turning <input type="checkbox"/> ejection <input type="checkbox"/> illness <input type="checkbox"/> assault <input type="checkbox"/> other	<input type="checkbox"/> object in aisle <input type="checkbox"/> struck by object <input type="checkbox"/> dispute with others <input type="checkbox"/> disturbance <input type="checkbox"/> faulty equipment <input type="checkbox"/> soiled clothing
---	--	--	--

PEDESTRIAN ACCIDENT (check one or more)

<input type="checkbox"/> with signal <input type="checkbox"/> diagonally	<input type="checkbox"/> against signal <input type="checkbox"/> sidewalk vehicle	<input type="checkbox"/> no signal <input type="checkbox"/> bicycle	<input type="checkbox"/> in crosswalk <input type="checkbox"/> not in crosswalk <input type="checkbox"/> other pedestrian accident
---	--	--	--

SHOW BY "X" MARK THE POINT OF CONTACT ON YOUR COACH AND OTHER VEHICLE

--	--	--

TOTAL NUMBER PASSENGERS _____

TOTAL NUMBER OF NAMES _____

OPERATOR'S
SIGNATURE _____DATE OF
REPORT _____

DESCRIBE ACCIDENT OR OCCURRENCE IN DETAIL: IMPORTANT-include any statement by other party

[illegible]

~~REVIEW REQUESTED~~

YES ☐

NO ☐

SIGNED

COMMENTS BY INTERVIEWING SUPERVISOR

[illegible]

INTERVIEWER

DATE INTERVIEWED